Department of Public Health
Bureau of Substance Abuse Services

APPLICATION FOR LICENSE OR APPROVAL OF SUBSTANCE ABUSE TREATMENT PROGRAM

INSTRUCTIONS

Completion of Application: Carefully review the entire application package before completing the application.

Applicants must be in compliance with requirements of 105 CMR 164 Licensure of Substance Abuse Treatment Programs. Submission of an application constitutes affirmation that applicant is fully compliant with requirements of 105 CMR 164.

Applications must be completed as follows:

1. Complete information requested on pages 1, 2, 3 and 4.

2. Complete all items. If an item is not applicable to your program, note "N/A" in the space provided or in the listing of Tabs (application documentation).

3. The "Attestations and Certifications" section on page 4 must be signed in ink by the specified applicant authorities.

5. Signatures must be witnessed and confirmed by a notary public.

6. The listing of required application documentation begins on page 5. Information requested must be provided in the form and order specified -- that is, narrative descriptions when instructed to "describe" and forms, policies, certificates, etc. attached when required.

7. Tables included with this package must be used to record requested information; applicants may make copies of these tables as needed. All required tables are at the end of the application. Insert completed tables in the application under the appropriate Tab.

8. Enter applicant program name in the space provided at the top of each page.

9. Each documentation item must be numbered as specified in the "Tab No." column. Note that the relevant regulatory section is listed in the right hand column to assist applicants in ensuring that the documentation provided complies with regulatory requirements. If a Tab is not applicable to your program, include a page listing the Tab Number and noting that it is "N/A."

10. Application documentation must be assembled in the order listed, with tabbed dividers between each numbered item.

11. Do not staple or bind documentation.

Submission of Application:

1. Copy pages 1, 2, 3 and 4, and send them with the non-refundable application fee of $300, plus $75 for each satellite and medication unit, to the address below. Please make the check payable to "DPH."

   Department of Public Health
   Bureau of Substance Abuse Services
   250 Washington Street, Third Floor
   Boston, MA 02108
   Attn: Gerry Romano

2. Mail or hand deliver the original of pages 1, 2, 3 and 4, and all application documentation, to the licensing inspector for your region as follows:

Metrowest:

Judi Robbins
Licensing Inspector
DPH Metrowest Regional Office
5 Randolph Street
Canton, MA 02021
781-828-7909
TTY: 781-828-7277
FAX: 781-828-7703

Greater Boston:

Ben Sullivan
Licensing Inspector
DPH Greater Boston Public Health Office
10 Malcolm X Blvd.
Roxbury, MA 02119
617-541-8306
TTY: 617-541-8314
FAX: 617-541-2861

Central & Western:

Erica M. Piedade
Licensing Inspector
DPH Western MA Regional Health Office
23 Service Center
Northampton, MA 01060
413-586-7525, x1182
TTY: 800-769-9991
FAX: 413-784-1037

Northeast:

Ann Canavan
Licensing Inspector
Northeast Regional Health Office
Tewksbury Hospital
365 East Street
Tewksbury, MA 01876
978-851-7261, x 4023
TTY: 978-851-0829
FAX: 978-640-1027

Southeast:

Ruth Karmelin-Bice
Licensing Inspector
DPH Southeast Regional Health Office
1736 Purchase Street
New Bedford, MA 02740
508-984-0624
TTY: 508-984-0636
FAX: 508-984-0605

Department of Public Health
Bureau of Substance Abuse Services
APPLICATION FOR LICENSE OR APPROVAL OF
SUBSTANCE ABUSE TREATMENT PROGRAM

Program Legal Name:			
Program Location Address: Street:			Tel: TTY/TDD: Fax:
City:	State: Massachusetts	Zip:	
Program Mailing Address: **NOTE: This is the address BSAS will use to send license and all other notices.** Street:			Tel: TTY/TDD: Fax:
City:	State: Massachusetts	Zip:	
Satellites and/or Medication Units: ☐ **NO** ☐ **YES** **If YES, complete page 2**			
Applicant (Corporate) Legal Name:			
Applicant (Corporate) Mailing Address: Street:			Tel: TTY/TDD: Fax:
City:	State:	Zip:	

Applicant Organization Type:

☐ Commonwealth of Massachusetts Department, Agency or Institution

☐ Corporation, specify whether: ☐ For Profit, or ☐ Not for Profit (attach 501 C(3) certificate) Incorporated in (state):

☐ Partnership ☐ Sole Proprietor ☐ Other: specify:

EIN/TIN:

Licensing Application For: ☐ New Program ☐ Existing Program (Renewal)

Is program funded by BSAS? ☐ **Yes** ☐ **No**

CURRENT LICENSES, APPROVALS and ACCREDITATIONS: Complete the table below. Enter "N/A" if license, approval or accreditation is not applicable. Include copies of licenses, approvals and accreditations in **Appendix A** of the application, using numbered tabs as listed below. If the program contains satellite(s) and/or medication unit(s), complete page 2. Include copies of licenses, approvals and accreditations for these locations, placing these copies behind the main program documents in the numbered tabs.

Appendix A Tabs	Licenses/Approvals	License/Approval Numbers	Expiration Dates
1	MA-DPH/BSAS License:		
2	MA-DPH/DHCQ:		
3	MA-DMH		
4	MA-FD Controlled Substance Registration		
5	MA-FD Controlled Substance Registration for Suboxone		
6	US-DEA Controlled Substance Registration		

Accreditations: Identify accrediting body:		**Dates of Current Accreditation** Start	End
7	**Joint Commission** (formerly JCAHO)		
8	**CARF**		
9	**COA**		
10	**Other:**		

Program Name: **Application Date:** MO_____ YR_____

Satellites and Medication Units: List locations, services provided and current licenses, approvals and accreditations for all satellites and medications units. Attach licenses, approvals and accreditations in **Appendix A,** behind those included for the program. Make additional copies of this page if needed, and include these additional pages in your submissions.

☐ **Satellite Office** ☐ **Medication Unit**

Location Address:
Street: Telephone:
City: State: Massachusetts Zip:

SERVICES PROVIDED AT THIS LOCATION:

☐ **OUTPATIENT SERVICES:** *Check if prescribing suboxone:* ☐ **Special Populations:**

- ☐ Driver Alcohol Education
- ☐ Counseling
- ☐ Operating Under the Influence Offender Aftercare
- ☐ Day Treatment

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

☐ **OPIOID TREATMENT:** *Check if administering:* ☐ Methadone ☐ Suboxone **Special Populations:**

- ☐ Detoxification
- ☐ Maintenance

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

Appendix A Tabs	Licenses/Approvals	License/Approval Numbers.	Expiration Dates
2	MA-DPH/DHCQ:		
4	MA-FD Controlled Substance Registration		
5	MA-FD Controlled Substance Registration for Suboxone		
6	US-DEA Controlled Substance Registration		

	Accreditations: Identify accrediting body:	Dates of Current Accreditation Start	End
7	**Joint Commission** (formerly JCAHO)		
8	**CARF**		
9	**COA**		
10	**Other:**		

☐ **Satellite Office** ☐ **Medication Unit**

Location Address:
Street: Telephone:
City: State: Massachusetts Zip:

SERVICES PROVIDED AT THIS LOCATION:

☐ **OUTPATIENT SERVICES:** *Check if prescribing suboxone:* ☐ **Special Populations:**

- ☐ Driver Alcohol Education
- ☐ Counseling
- ☐ Operating Under the Influence Offender Aftercare
- ☐ Day Treatment

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

☐ **OPIOID TREATMENT:** *Check if administering:* ☐ Methadone ☐ Suboxone **Special Populations:**

- ☐ Detoxification
- ☐ Maintenance

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

Appendix A Tabs	Licenses/Approvals	License/Approval Numbers.	Expiration Dates
2	MA-DPH/DHCQ:		
4	MA-FD Controlled Substance Registration		
5	MA-FD Controlled Substance Registration for Suboxone		
6	US-DEA Controlled Substance Registration		

	Accreditations: Identify accrediting body:	Dates of Current Accreditation Start	End
7	**Joint Commission** (formerly JCAHO)		
8	**CARF**		
9	**COA**		
10	**Other:**		

Program Name: **Application Date:** MO_____ YR_____

SERVICES PROVIDED

☐ **ACUTE SERVICES:**

- ☐ Acupuncture Detoxification
- ☐ Outpatient Detoxification
- ☐ Inpatient Detoxification: Specify
  - ☐ Medically Managed ***No. of beds:*** *Check if providing:* ☐ Methadone ☐ Suboxone
  - ☐ Medically Monitored ***No. of beds:*** *Check if providing:* ☐ Methadone ☐ Suboxone
  - ☐ Clinically Managed ***No. of beds:*** *Check if providing:* ☐ Methadone ☐ Suboxone

Special Populations:

☐ Adolescent ☐ Pregnant Women ☐ Section 35
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

☐ **OUTPATIENT SERVICES:** *Check if prescribing suboxone:* ☐

- ☐ Driver Alcohol Education
- ☐ Counseling
- ☐ Operating Under the Influence Offender Aftercare
- ☐ Day Treatment

Special Populations:

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorder

☐ **OPIOID TREATMENT:** *Check if administering:* ☐Methadone ☐Suboxone

- ☐ Detoxification
- ☐ Maintenance

Special Populations:

☐ Adolescent ☐ Pregnant Women
☐ Disabled ☐ Elders (60+)
☐ Persons with co-occurring disorders

☐ **RESIDENTIAL REHABILITATION:**

- ☐ Adults: Specify:
  - ☐ Transitional Support Services ***Number of beds:***
    - ☐Male ☐ Female ☐Co-ed
  - ☐ Social Model Recovery Home ***Number of beds:***
    - ☐Male ☐ Female ☐Co-ed
  - ☐ Recovery Home ***Number of beds:***
    - ☐Male ☐ Female ☐Co-ed
  - ☐ Therapeutic Community ***Number of beds:***
    - ☐Male ☐ Female ☐Co-ed
- ☐ Adolescents: ***Number of beds:*** ☐Male ☐ Female ☐Co-ed
- ☐ Adults with their Families: ***Number of families:***
- ☐ Operating Under the Influence Second Offender: ***Number of beds:*** ☐Male ☐ Female ☐Co-ed

Special Populations:

☐ Pregnant Women
☐ Disabled
☐ Elders (60+)
☐ Persons with co-occurring disorders

RESPONSIBLE OFFICIALS

Officer of Governing Body: *(e.g. president, chairperson of board)*		**Title:**
Street Address:		T el : Fax :
City:	State:	Zip:
Email address:		

Executive Director:		
Street Address:		T el : Fax
City:	State:	Zip:
Email address:		

Program Director:		
Street Address:		T el : Fax
City:	State:	Zip:
Email address:		

Program Name: **Application Date:** MO_____ YR_____

ATTESTATIONS and CERTIFICATIONS:

I/We hereby certify under the penalties of perjury that to the best of my/our knowledge:

No license or approval held by this applicant to operate any health care facility in any jurisdiction has been revoked, suspended or limited;

No civil action or criminal charge related to the delivery of service or which may affect continued operation is currently pending against the applicant or any person employed by the applicant;

At all times on each shift at least one person is certified and present to perform cardio-pulmonary resuscitation and one person is trained and present to provide first aid;

The program has established All Hazards and Emergency Planning and Procedures;

The program has established policy and procedures for investigating and reporting incidents of alleged or suspected physical or sexual assault, abuse or neglect;

As required by M.G.L.c. 62C, §49A, the applicant has complied with all laws of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support;

The applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health; and

The information included in this application and submitted to the Department related to this application is true.

_____ _____

Officer of Governing Body Date

_____ _____

Executive Director Date

Commonwealth of Massachusetts

County of _____

On this _____ day of _____, 20__, before me, the undersigned notary public, personally appeared the above named persons, proved to me through satisfactory evidence of identification, which were _____ _____ and _____ _____to be the persons who signed the preceding document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of their knowledge and belief.

_____

Notary Public

My Commission Expires on

Application Documentation:

The following pages list documentation which must be submitted with the application.

All documentation must be included at the time of application submission. **Applications with incomplete documentation will be returned.**

Attach documentation in the order listed, with each item labeled with a separate tab.
Applications not conforming to this requirement will be returned.

Each item of documentation must comply with 105 CMR 164 Licensure of Substance Abuse Treatment Programs. Relevant sections of regulations are listed to the right of each item for reference.

Program Name: **Application Date:** MO_____ YR_____

TAB No.	Application Documentation: Requirements for All Levels of Care	Regulation Section
	PROGRAM DESIGN	
1	**Treatment Goals and approach**: Describe applicant's service, including the following, listed in the order presented below, and identified by letter and topic (e.g. "a. Program Goals…"). **a. Program Goals, Objectives and Philosophy:** Include description of program expertise, target populations, expected outcomes. **b. Treatment Methods:** Describe treatment methods used, specifying how treatment methods are expected to achieve program goals. Include standards used to determine appropriateness of methods, identifying which methods are evidence-based. **c. Special Populations:** Describe special populations served and design of programs for these populations. **d. Method of Assessing Effectiveness** of services, including methods for determining client satisfaction.	**164.037** **164.038** **164.074**
2	**Admission and Exclusion Criteria**: Attach policies and procedures describing the following, in the order presented below and identified by letter and topic. **a. Admission Criteria:** Include special populations served; and **b. Exclusion Criteria:** Include process for referring excluded individuals to appropriate care	**164.070**
3	**Completion and Discharge**: Attach policies and procedures for the following, in the order presented below and identified by letter and topic: **a. Successful Completion of Treatment** **b. Voluntary Discharge** **c. Involuntary Discharge** NOTE: Opioid Treatment Programs are not required to submit these policies & procedures. **d. Appeal Process** **e. Transfer and Referral**	**164.075**
4	**Preventing Discharge to a Shelter:** Describe steps taken to prevent discharge to a homeless shelter.	**164.075**
5	**Grievances:** Attach policy and procedures governing resolution of client disagreements or disputes.	**164.080**
6	**Client Policy Manual:** Attach copy of client policy manual. Attachment constitutes affirmation that contents of client policy manual comply with 105 CMR 164.081.	**164.081**
7	**Client Record:** Attach sample of client record forms and formats (**new applications only**).	**164.083**
8	**Marketing:** Attach copies of any written marketing materials (e.g., advertisements, brochures) describing applicant and applicant's substance abuse treatment services. Include hard copy of program information appearing on applicant's web pages and list website address.	**164.036**

TAB No.	Application Documentation: Requirements for All Levels of Care	Regulation Section
	GOVERNANCE AND ADMINISTRATION	
9	**ADA/504 Compliance Checklist:** Attach completed checklist.	**164.009**
10	**Governing Body**: Attach the following, in the order presented below and identified by letter and topic: **a. Membership:** Using the table provided, list governing body member names, addresses, telephone numbers, office held, area(s) of expertise and term. Record whether governing body includes persons in recovery from a substance use disorder. **b. Advisory Board**: If governing body does not include members who are in recovery, describe: i. efforts made to recruit and retain such members; ii. advisory board of such representatives, omitting names; and iii. method for obtaining annual review of agency services and programs by this advisory board. **c. Massachusetts Representation**: if governing body is located outside of Massachusetts, use the table provided to list the names and contact information of Massachusetts residents' advisory board and affirm inclusion of at least one person in recovery from a substance use disorder.	**164.030**
11	**Financial Interest**: List all employees with an ownership or financial interest in the service, program or agency, including the nature of such interest and benefit received by the employee.	**164.030**
12	**Organizational Structure:** Attach a chart showing the agency's organizational structure, including key program staff, lines of authority, reporting responsibility, communication and staff assignment.	**164.030**
13	**Finances:** Attach the following information, listed in the order presented below and identified by letter and topic **a. Summary Audit Letter** from most recent fiscal year end audit **b. Last Fiscal Year Operating Budget** **c. Current Fiscal Year-to-Date Operating Budget**	**164.032**
14	**Insurance:** Attach a list of insurance policies held for each program location, including satellites and medication units, identifying which policies cover which location(s). Include: commercial (general) and professional liability insurance and workers' compensation insurance. Attach copies of declaration pages.	**164.033**
15	**Qualified Service Organization Agreements:** List all QSOAs currently in effect, specifying the affiliated organization, purpose and term of the agreement. Where applicable, identify the following QSOAs in the order listed: **a. Emergency and inpatient medical and psychiatric** care. **b. If serving pregnant women**: i. QSOA(s) for emergency obstetrical and medical back-up for pregnant women ii. QSOA(s) for parent-child services if serving pregnant women **c.** QSOA(s) for mental health interventions and coordination of care for persons with **co-occurring disorders** **d.** If serving **elders**, QSOA(s) with organization serving the elderly	**164.034** **164.082**
16	**Civil Action or Criminal Charges:** List any civil actions or criminal charges brought against applicant or any person employed by applicant within the past two years, which is related to the delivery of service or which may affect continued operation of the facility. Note if any of these actions are currently pending.	**164.035**

TAB No.	Application Documentation: Requirements for All Levels of Care	Regulation Section
17	**Inspections:** Attach copies of the following inspection certificates in the order presented below, and identified by letter and topic: **a. Building Inspection** **b. Fire Inspection**	**164.050**
	PERSONNEL	
18	**Personnel Policies and Procedures:** Attach the following personnel policies and procedures, in the order presented below and identified by letter and topic: **a. Criminal Offender Record Check:** Include method for ensuring compliance for interns, volunteers, and contract or temporary staff. **b. TB Screening**	**164.041**
19	**Job Descriptions:** Attach job descriptions for all positions, including Access, HIV/AIDS and Tobacco Education Coordinators. Include salary range, responsibility, supervision received, supervision required, authority and qualifications.	**164.043**
20	**Training:** Describe the following, in the order presented below and identified by letter and topic. **a. Staff Orientation:** Include method for ensuring inclusion of volunteers, student interns, contract and temporary staff. **b. Schedule of monthly in-service training for previous 12 months:** Include topic, presenter and duration of training session. **c. HIPAA and 42 CFR:** Describe method for training staff on requirements of HIPAA and 42 CFR; include frequency, duration and method of documenting participation in training. **d. Specialized Training:** Schedule of training for Access Coordinator, HIV/AIDS and Tobacco Education Coordinator **e. HIV/AIDS Education:** Schedule, including subject, presenter and duration of training to develop staff skills regarding HIV/AIDS. **f. Tobacco Education:** identify staff who have completed tobacco treatment basic skills training specified by the Department; include date training completed.	**164.044**
21	**Supervision:** Describe the following, in the order presented below and identified by letter and topic: **a. Supervisory Responsibilities:** Identify supervisors and supervisees, including supervisors of volunteers, student interns and contract or temporary staff. **b. Clinical Supervision Schedule:** Describe the supervisory schedule and method of documenting clinical supervision provided for all clinical staff, including volunteers, student interns and contract or temporary staff. **c. Non-Clinical (Administrative) Supervision:** Describe supervisory schedule and method of documenting supervision for non-clinical (administrative) staff.	**164.044** **164.047**
Staffing Pattern:		
22	**Staff List:** Using the table provided at the end of the application, list all staff positions, incumbents, their qualifications, FTE directly related to the program's substance abuse treatment services, and whether employee, intern, volunteer, fee-for-service, contract, or temporary; list hours of in-service training in previous 12 months. If majority of community served speaks a language other than English, identify staff who speak major languages of community.	**164.041** **164.048**
23	**Staff Schedule:** Using the table provided, list daily staff schedule, identify CPR certified staff, and emergency designee. Tables are designated for each day of the week.	
24	**Multi-Disciplinary Review:** Describe method of providing multidisciplinary review, including participants (specify if by QSOA), frequency, and how the review is documented.	**164.048**

TAB No.	Application Documentation: Requirements for All Levels of Care	Regulation Section
	SERVICE COMPONENTS: REQUIRED FOR ALL LEVELS OF CARE	
25	**Referrals:** Describe sources of referrals and process of receiving referrals.	**164.070**
26	**Orientation:** Describe orientation for new and returning clients.	**164.071**
27	**Assessment:** Describe assessment process, listed in the order presented below and identified by letter and topic: **a. Appropriateness:** Method for determining appropriateness of care in relation to client's treatment need(s), including standards used to formulate diagnosis. **b. Assessment of Infections Disease Risk:** Attach protocols used to assess clients' risks related to HIV, TB and Viral Hepatitis. **c. Additional Evaluations:** Method for obtaining additional evaluations when needed.	**164.072**
28	**Individual Treatment Plan:** Describe process of development and review of Individual Treatment Plans.	**164.073**
29	**Discharge Plan:** Describe process for development of discharge plan, including clients' participation in discharge planning.	**164.075**
30	**Aftercare:** Attach policy and procedure for aftercare, including referrals.	**164.076**
31	**Post-Discharge Follow-Up:** Attach policy and procedure for post-discharge follow-up.	**164.077**

TAB No.	Application Documentation: Requirements for Specific Levels of Care	Regulation Section
	ACUTE SERVICES: Acupuncture	
32	**Services:** In addition to services described under Tabs 25 through 31, describe, in the order listed below, identified by letter and topic: **a. Acupuncture Treatments:** Criteria for determining frequency of treatment **b. Counseling:** Criteria for determining frequency and methodology of counseling services **c. Outreach:** Provision of outreach services	**164.113**
33	**Consultation:** Describe method for ensuring consultation with fully qualified clinician, and physician, psychiatrist, nurse practitioner, physician assistant, registered nurse or licensed practical nurse.	**164.114**
	ACUTE SERVICES: Outpatient Detoxification	
34	**Treatment Programming:** In addition to services described under Tabs 25 through 31, attach schedule of treatment programming.	**164.123**
35	**Consultation:** Describe method for providing consultation to staff by a qualified physician.	**164.124**
	ACUTE SERVICES: Inpatient Detoxification Services	
35	**Treatment Programming:** In addition to services described under Tabs 25 through 31, attach schedule of treatment programming.	**164.133**
36	**Staffing:** In addition to staff listed under Tab 24, provide the following: **a. Consultation:** Describe method for providing consultation to staff by a qualified physician **b. Food Service Personnel:** If providing direct food service (i.e., not purchased), attach evidence of training of food service personnel in safe and sanitary food handling and preparation.	**164.134**
37	**Purchased Food Services:** Attach copies of food service provider current license and inspection.	**164.138**
38	**Storage and Administration of Medication** (Clinically Managed Detoxification Only): Attach policy and procedure for storage, monitoring, administration and disposal of medication.	**164.139**
	OUTPATIENT SERVICES: Driver Alcohol Education	
39	**Assessment:** In addition to services described under Tabs 25 through 31, describe process used in assessing developmental status of clients under the age of 21.	**164.212**
40	**Treatment:** Describe the following, in the order presented below and identified by letter and topic: **a. Group Education:** Attach curriculum used for group education, and weekly group schedule, specifying staff leading group sessions. **b. Alternative Programming:** Describe alternative programming provided to: i. Clients under 21 years of age ii. Clients who do not speak English iii. Accommodate clients' employment or other obligation iv. Accommodate clients suffering from mental health disorders which limit ability to participate	**164.212**

Program Name: **Application Date:** MO_____ YR_____

TAB No.	Application Documentation: Requirements for Specific Levels of Care	Regulation Section
	OUTPATIENT SERVICES: Operating Under the Influence Second and Multiple Offenders	
41	**Operating Under the Influence Second and Multiple Offender Aftercare:** Describe the following, in the order presented below, and identified by letter and topic: **a. Alcohol and Drug Screening** **b. Reports to Referring Court or Agency**	**164.223**
42	**Psychiatrist/Psychologist:** Attach resume (and QSOA, if applicable) of licensed psychiatrist or psychologist.	**164.224**
	OUTPATIENT SERVICES: Day Treatment	
43	**Treatment Programming:** In addition to services described under Tabs 25 through 31, attach schedule of treatment programming, specifying staff providing each service and/or leading groups.	**164.232**
44	**Psychiatrist/Psychologist:** Attach resume (and QSOA, if applicable) of licensed psychiatrist or psychologist.	**164.233**
	OPIOID TREATMENT	
45	**Admission:** In addition to services described under Tabs 25 through 31, describe the following, in the order presented below and identified by letter and topic: **a. Assessment:** Attach protocols used to assess patient's current prescription medications in relation to opioid agonist medications. **b. Women of Child Bearing Age:** Describe process of completing pregnancy tests prior to administering opioid agonist or prior to detoxification.	**164.302**
46	**Verification:** Describe process for verifying that clients with positive initial screens for methadone are not enrolled in other opioid treatment programs.	**164.302**
47	**Dosage:** Describe protocols followed to establish and adjust dosing levels.	**164.302 - 304**
48	**Pregnant Women:** Describe protocols followed in providing opioid treatment for pregnant women	**164.304**
49	**Diversion Control:** Describe methods used to control diversion.	**164.308**
50	**Severe Weather Accommodation:** Attach policy and procedure for ensuring continued dispensing of medication in the event of severe weather conditions.	**164.316**
	RESIDENTIAL REHABILITATION: All Programs	
51	**Chores:** Attach policy and procedure for client performance of household chores, including process of instruction, scheduling, and specifying chores performed.	**164.053**
52	**Food Handling and Preparation:** **a. Purchased Food Services:** Attach copies of food service licenses documenting compliance of provider with 105 CMR 590; attach copy of provider's board of health inspection. **b. Resident Food Preparation:** If residents prepare and/or serve meals, describe training in sanitary food handling and preparation provided. Attach copies of SafeServ certificates and record of training provided.	**164.405**
53	**Storage and Administration of Medication**: Attach policy and procedure for storage, monitoring, administration and disposal of medication.	**164.406**
	RESIDENTIAL REHABILITATION FOR ADULTS	
54	**Program Schedule:** In addition to services described under Tabs 25 through 31, describe daily schedule, including clinical group services and planned activities.	**164.423**

TAB No.	Application Documentation: Requirements for Specific Levels of Care	Regulation Section
	RESIDENTIAL REHABILITATION FOR ADULTS WITH THEIR FAMILIES	
55	**Assessments and Treatment Plans:** In addition to services described under Tabs 25 through 31, describe process for completing assessments and treatment plans for all family members in the program.	**164.430**
56	**Services:** Describe the following, in the order presented below and identified by letter and topic: **a. Substance Abuse Treatment:** Describe coordination of substance abuse treatment services provided to adult and adolescent residents, including schedule of case review, staff coordinating services, and agencies providing services through QSOAs. **b. Mental Health Services:** Describe process for referring and obtaining mental health services for residents. **c. Parenting and Life Skills Education:** Describe process for providing parenting and life skills education. **d. Transitional Assistance and Employment:** Describe advocacy services provided to assist families in applying for transitional assistance and seeking employment. **e. Services for Children:** Describe services provided directly or through referral for children in the program. Describe affiliations with: early intervention, schools, Departments of Youth Services and of Children and Families.	**164.432**
57	**Supervision of Children:** Describe process for ensuring adult supervision of children at all times.	**164.059**
	RESIDENTIAL REHABILITATION FOR ADOLESCENTS	
58	**Assessment:** In addition to services described under Tabs 25 through 31, if using protocol other than GAIN, attach protocols used to assess client's developmental, educational and mental health status.	**164.442**
59	**Treatment:** Describe the following, in the order presented below and identified by letter and topic: **a. Educational Programming** **b. Family Involvement** **c. Schedule of Treatment Programming,** including gender specific programming, programming which addresses cultural, ethnic and/or gender identity, and recreational programming.	**164.442**
	RESIDENTIAL REHABILIATION FOR OPERATING UNDER THE INFLUENCE SECOND OFFENDERS	
60	**Treatment Programming:** In addition to services described under Tabs 25 through 31, attach a schedule of treatment program and daily activities.	**164.452**

APPENDIX A:
Copies of Current Licenses, Approvals and Accreditations

Program Name: **Application Date:** MO_____ YR_____

TAB 10a.	**List all Members of Governing Authority:** Name, address, phone number, office, area of expertise (i.e., identify experts in management, finance and substance use disorder treatment), and term of office.			
	Identifying Information	**Office in Governing Authority**	**Expertise**	**Term of Office**
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	
	Name: **Address:** **Phone:**		☐ Financial ☐ Management ☐ Substance Abuse Treatment ☐ Other	

At least one member of the governing body is in recovery from a substance use disorder: ☐ Yes ☐ No

If No, complete description requested for Tab 10b, **Advisory Board** on page 7.

Program Name: **Application Date:** MO_____ YR_____

TAB 10c.	**Massachusetts Advisory Board:** to be completed if governing body is not in Massachusetts. List name, address, phone number of Massachusetts Advisory Board
	Identifying Information
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone:**
	Name: **Address:** **Phone**:
	Name: **Address:** **Phone:**

At least one member of the Advisory Board is in recovery from a substance use disorder: ☐ Yes ☐ No

If No, complete description requested for Tab 10b, **Advisory Board** on page 7.

Program Name: **Application Date:** MO____ YR____

STAFF LIST: Include at TAB 22. List below all current management and direct services staff; their credentials; experience; FTE; whether employee, intern, volunteer, FFS, contract or temporary staff; and number of in-services attended. Attach additional sheets if necessary. Note if position is "not applicable" to applicant's level of care.

Position	Full Name	Highest Educ. (degree/year)	Current Certification or License		Years Experience in Field	FTE in Substance Abuse Treatment	Employee, Intern, Volunteer, FFS, Contract or Temp	No. of In-Service Trainings in Previous 12 Months
			Discipline & Lic/Cert/Registr. Number	Expiration Date				
Program Director								
Medical Director								
Senior Clinician								
Clinical Staff: (specify position)								
Nursing Supervisor								
Qualified Health Care Professionals: (specify position)								
Support Staff:								
Cook								
Driver								

Attach Resumes of Incumbents: ☐ Program Director ☐ Medical Director

☐ Senior Clinicians (FTE to substance abuse treatment) ☐ Senior Clinician specializing in services to youth (164.082(B))

☐ Family Therapist (if providing Residential Rehabilitation for Adults with their families) ☐ Acupuncturist (if providing Acupuncture Detoxification)

Languages Spoken: If majority of community served speaks a language or languages other than English, list below names of substance abuse treatment staff who are fluent in these languages, listing the language spoken by the staff person.

Staff	Language	Staff	Language
Staff	**Language**	**Staff**	**Language**
Staff	**Language**	**Staff**	**Language**
Staff	**Language**	**Staff**	**Language**

Program Name: **Application Date:** MO_____ YR_____

STAFF SCHEDULE: Include at Tab 23

MONDAY: List Hours of Operation:

Shift	Staff		Check if CPR Certified	Check if Emergency Designee
	Full Name	Position		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

TUESDAY: **List Hours of Operation:**				
Shift	**Staff**		**Check if CPR Certified**	**Check if Emergency Designee**
	Full Name	**Position**		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

WEDNESDAY: List Hours of Operation:				
Shift	**Staff**		**Check if CPR Certified**	**Check if Emergency Designee**
	Full Name	**Position**		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

THURSDAY: **List Hours of Operation:**				
Shift	**Staff**		**Check if CPR Certified**	**Check if Emergency Designee**
	Full Name	**Position**		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

FRIDAY: **List Hours of Operation:**				
Shift	**Staff**		**Check if CPR Certified**	**Check if Emergency Designee**
	Full Name	**Position**		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

SATURDAY: List Hours of Operation:

Shift	Staff		Check if CPR Certified	Check if Emergency Designee
	Full Name	Position		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Program Name: **Application Date:** MO_____ YR_____

SUNDAY: **List Hours of Operation:**				
Shift	**Staff**		**Check if CPR Certified**	**Check if Emergency Designee**
	Full Name	**Position**		
Day			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Evening			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
Overnight			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐